Notice of Group Life Insurance Conversion Privilege

Metropolitan Life Insurance Company, New York, NY

This Notice is not a conversion application or policy. Do not mail this form to MetLife or the group policyholder.

Instructions

Instructions to policyholder/recordkeeper:
Complete this Notice and provide a copy to the employee when group coverage terminates or reduces. If coverage has been assigned, provide notice to the Assignee.

Instructions to eligible person:
You may convert your coverage to an individual life insurance policy, which will be issued without medical examination if you apply for it and pay the required premium within the application period.

Application period:
The application period is based on the date your group coverage terminates and the date of this Notice. Generally, you have 31 days from the date group coverage ends to apply for conversion. However, if this Notice is dated more than 15 days from date of termination, your application period is extended for an additional 15 days from the date of this Notice. If the 15-day extension applies to you, it will not exceed more than 91 days from the date group insurance was terminated.

The conversion application period is time-sensitive. If you are interested in converting your group coverage, you can meet with a licensed financial professional and complete an application. MetLife has an exclusive arrangement for financial professionals from Massachusetts Mutual Life Insurance Company (MassMutual) to explain your options. Call us at 877-275-6387 to arrange for a local MassMutual financial professional to contact you directly, usually within 48 hours of your request.

Eligible person / Employee information

Date of this Notice *(mm/dd/yyyy)*	Date Group Coverage terminates or reduces *(mm/dd/yyyy)*

Insured

First name	Middle name	Last name

Relationship to Employee	Gender	Date of Birth *(mm/dd/yyyy)*
☐ Self ☐ Dependant	☐ Male ☐ Female	

Owner *If certificate is assigned*

First name	Middle name	Last name

Gender	Date of Birth *(mm/dd/yyyy)*
☐ Male ☐ Female	

Dependent *If applicable*

First name	Middle name	Last name

Gender	Date of Birth *(mm/dd/yyyy)*
☐ Male ☐ Female	

Address of Insured/Owner	City	State	ZIP

Phone number

Date Group Life benefits became effective for insured *(mm/dd/yyyy)*

Reason for termination: ☐ Termination of employment ☐ Termination of Group Policy or Class
☐ Retirement ☐ No longer an eligible dependent ☐ Total Disability

Coverage Information

If coverage is terminating or reducing, complete the applicable fields below.
If an accelerated benefits option claim was paid, be sure to reduce the amount available for conversion by the ABO claim amount.

Coverage type	Group Policy report number	Coverage amount
Basic Life		**$**
Supplemental Life		**$**
Dependent Spouse Life		**$**
Dependent Child Life		**$**
Group Universal Life		**$**
Group Variable Universal Life		**$**
Survivor		**$**

Group Policyholder
Name

Address	City	State	ZIP

Phone number

Authorized Group Policyholder representative *(print)*
Name

MetLife Transition Solutions